

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 6628
1709

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		179	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>5953 Gates Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>5953 Gates Ave.</u>			
3. NAME OF DECEASED a. (First) <u>Mary</u>		b. (Middle) _____		c. (Last) <u>Ryan</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2 - 22 - 49</u>	
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____		8. DATE OF BIRTH <u>June 13, 1875</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Louis Temm</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Hanson</u>		14. NAME OF HUSBAND OR WIFE <u>Frank X. Ryan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr. Frank Linn, 5953 Gates Ave.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chr Myocarditis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>920</u> <u>4200</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>11/23</u> 19 <u>41</u> , to <u>2/22</u> 19 <u>49</u> , that I last saw the deceased alive on <u>2/22</u> , 19 <u>49</u> , and that death occurred at <u>2:30</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Arthur J. Donnelly</u> (Degree or title) _____				23b. ADDRESS <u>5899 Delmar</u>		23c. DATE SIGNED <u>2/22/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-24-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>FEB 23 1949</u>		REGISTRAR'S SIGNATURE <u>J B Laster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur J. Donnelly 3845 Lindell Blvd</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

5879 New York

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Student Embalmer No. _____
working under my personal supervision.

Signed _____

W. H. Van Matre

Signed _____
Student Embalmer

Licensed Embalmer No. _____

2825

P. O. Address _____

4340 Lafayette

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.